		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020438

Facility Name: Aspire on Eastern

Address: 105 Eastern Ave (Number) Bellwood (City) 60104 (Zip Code)

County: Cook

Telephone Number: 708-547-3550 **Fax #** 708-547-4067

IDPA ID Number: 362654558-001

Date of Initial License for Current Owners:

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 c 3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: James B. O'Brien **Telephone Number:** 708-547-3550

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/01 to 6/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) 9/30/02 (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	82	Intermediate/DD	82	29,930	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	29,930	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	29,602			29,602	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,602			29,602	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.90%

D. How many bed-hold days during this year were paid by Public Aid?
138 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 03/01/75

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [xx] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Aspire on Eastern # 0020438 **Report Period Beginning:** 7/01/01 **Ending:** 6/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	205,397	12,911	9,375	227,683	61	227,744		227,744			1
2	Food Purchase		140,686		140,686	248	140,934		140,934			2
3	Housekeeping	197,227	50,223		247,450	3,800	251,250		251,250			3
4	Laundry	39,392	6,849		46,241		46,241		46,241			4
5	Heat and Other Utilities			83,538	83,538	5,065	88,603		88,603			5
6	Maintenance	122,245	23,789	29,153	175,187	12,177	187,364		187,364			6
7	Other (specify):*											7
8	**TOTAL General Services**	564,261	234,458	122,066	920,785	21,351	942,136		942,136			8
	B. Health Care and Programs											
9	Medical Director			20,417	20,417		20,417		20,417			9
10	Nursing and Medical Records	307,025	59,505		366,530		366,530		366,530			10
10a	Therapy											10a
11	Activities	1,603,086	69,984		1,673,070		1,673,070		1,673,070			11
12	Social Services	176,139	7,512	39,201	222,852		222,852		222,852			12
13	Nurse Aide Training	20,824			20,824		20,824		20,824			13
14	Program Transportation	7,250	39,288		46,538		46,538		46,538			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,114,324	176,289	59,618	2,350,231		2,350,231		2,350,231			16
	C. General Administration											
17	Administrative	46,262		150,354	196,616	(150,354)	46,262		46,262			17
18	Directors Fees											18
19	Professional Services			5,897	5,897	31,625	37,522	(31,625)	5,897			19
20	Dues, Fees, Subscriptions & Promotions			7,843	7,843	7,342	15,185		15,185			20
21	Clerical & General Office Expenses	405,834	3,815	44,518	454,167	31,487	485,654	(13,789)	471,865			21
22	Employee Benefits & Payroll Taxes			501,150	501,150		501,150		501,150			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,593	1,593	1,681	3,274	(1,681)	1,593			24
25	Other Admin. Staff Transportation			3,945	3,945	3,430	7,375	(3,430)	3,945			25
26	Insurance-Prop.Liab.Malpractice			22,968	22,968	630	23,598		23,598			26
27	Other (specify):*											27
28	**TOTAL General Administration**	452,096	3,815	738,268	1,194,179	(74,159)	1,120,020	(50,525)	1,069,495			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,130,681	414,562	919,952	4,465,195	(52,808)	4,412,387	(50,525)	4,361,862			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Aspire on Eastern #0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			87,567	87,567	13,189	100,756	(6,344)	94,412			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,435	42,435	39,619	82,054		82,054			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			481	481		481		481			35
36	Other (specify):*											36
37	**TOTAL Ownership**			130,483	130,483	52,808	183,291	(6,344)	176,947			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			247,272	247,272		247,272		247,272			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			247,272	247,272		247,272		247,272			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,130,681	414,562	1,297,707	4,842,950		4,842,950	(56,869)	4,786,081			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,789)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(43,080)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (56,869)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (56,869)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Aspire on Eastern

ID# 0020438

Report Period Beginning: 7/01/01

Ending: 6/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aspire on Eastern # 0020438 **Report Period Beginning:** 7/01/01 **Ending:** 6/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(13,789)	0	0	0	0	0	0	0	0	0	0	(13,789)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(13,789)	0	0	0	0	0	0	0	0	0	0	(13,789)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13,789)	0	0	0	0	0	0	0	0	0	0	(13,789)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aspire on Eastern # 0020438 **Report Period Beginning:** 7/01/01 **Ending:** 6/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(13,789)	0	0	0	0	0	0	0	0	0	0	(13,789)	45

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [xx] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [xx] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Aspire of Illinois
Street Address: 9901 Derby Lane
City / State / Zip Code: Westchester, Il 60154
Phone Number: (708-547-3550
Fax Number: (708-547-4067

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Kitchen Supplies	Direct Cost	15,066,912	30	$ 189	$	4,853,826	$ 61	1
2	2	Food/Beverage	Direct Cost	15,066,912	30	771		4,853,826	248	2
3	3	Housekeeping Supplies	Direct Cost	15,066,912	30	4,943		4,853,826	1,592	3
4	3	Hskp. Other	Direct Cost	15,066,912	30	6,855		4,853,826	2,208	4
5	5	Utilities	Direct Cost	15,066,912	30	15,723		4,853,826	5,065	5
6	6	Maint. Supplies	Direct Cost	15,066,912	30	5,089		4,853,826	1,639	6
7	6	Maint. Other	Direct Cost	15,066,912	30	32,710		4,853,826	10,538	7
8	19	Prof. Services	Direct Cost	15,066,912	30	98,167		4,853,826	31,625	8
9	20	Dues, Fees, Other	Direct Cost	15,066,912	30	22,792		4,853,826	7,342	9
10	21	Clerical Supplies	Direct Cost	15,066,912	30	78,139		4,853,826	25,173	10
11	21	Telephone	Direct Cost	15,066,912	30	19,600		4,853,826	6,314	11
12	24	Travel Seminar	Direct Cost	15,066,912	30	5,217		4,853,826	1,681	12
13	25	Staff Travel	Direct Cost	15,066,912	30	10,647		4,853,826	3,430	13
14	26	Insurance	Direct Cost	15,066,912	30	1,957		4,853,826	630	14
15	30	Depreciation	Direct Cost	15,066,912	30	40,940		4,853,826	13,189	15
16	32	Interest	Direct Cost	15,066,912	30	122,984		4,853,826	39,619	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 466,723	$		$ 150,354	25

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Banco Popular		xx	Aspire on Eastern	$19,988.00	12/15/00	$ 2,000,000	$	12/15/20	8.7500	$ 42,435	1
2	Illinois Facilities		xx	9901 Derby Lane	$4,631.00	10/13/99	495,000		10/13/15	7.6500	11,350	2
3												3
4												4
5												5
	Working Capital											
6	Banco Popular		xx	Line of Credit							28,269	6
7												7
8												8
9	TOTAL Facility Related				$24,619.00		$ 2,495,000	$			$ 82,054	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,495,000	$			$ 82,054	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

N/A

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aspire on Eastern COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0020438

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,330 B. General Construction Type: Exterior Brick Frame metal Number of Stories one

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land	195,000	1975	$ 175,000	1
2					2
3	TOTALS	195,000		$ 175,000	3

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	82		1975	1975	$ 835,850	$ 20,896	40	$ 20,896	$	$ 543,078	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodeling			1975	4,485					4,485	9
10	Bldg Improvements			1976	7,736					7,736	10
11	Bldg Improvements			1979	290					290	11
12	Bldg Improvements			1980	6,047					6,047	12
13	Bldg Improvements			1981	9,890					9,890	13
14	Bldg Improvements			1982	2,925					2,925	14
15	Bldg Improvements			1984	1,012					1,012	15
16	Blacktopping			1980	11,625		15			11,625	16
17	Remodeling			1982	16,244		20	812	812	14,873	17
18	Patio			1983	4,095		10			4,095	18
19	Nurses Station			1983	2,065		10			2,065	19
20	Fan Shut Down			1983	2,136		10			2,136	20
21	Intercom			1984	1,412		10			1,412	21
22	Fence			1985	4,658		10			4,658	22
23	Fire Alarm			1985	1,358		10			1,358	23
24	Booster Water Temp			1985	1,415		10			1,415	24
25	Laundry Room			1986	7,775		30	260	260	4,290	25
26	tiling			1986	1,125		20	56	56	924	26
27	Garbage disposal			1986	1,159		10			1,159	27
28	A/C			1986	3,075		10			3,075	28
29	HVAC			1987	1,906		8			1,906	29
30	insulation			1987	6,639		20	332	332	5,146	30
31	Electrical			1987	28,350		20	1,418	1,418	21,979	31
32	Water Heater			1987	1,422		15	59	59	1,422	32
33	HVAC			1988	6,534		8			6,534	33
34	Electrical			1988	1,456		20	572	572	8,294	34
35	Water Cond.			1988	1,900		15	126	126	1,827	35
36	Paving			1989	18,732		15	1,248	1,248	16,848	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Water Softner	1989	$ 2,000	$	12	$	$	$ 2,000	37
38	HVAC	1989	9,774		8			9,774	38
39	Walk-in Cooler	1989	23,330		25	934	934	12,609	39
40	Front Enclosure	1989	3,595		20	180	180	2,430	40
41	Bldg. Addition	1992	464,250	15,474	30	15,474		170,214	41
42	Bdlg. Addition	1993	13,070	436	30	436		4,360	42
43	Doors	1990	5,072		10			5,072	43
44	HVAC	1990	7,878		8			7,878	44
45	Sink	1991	3,150		20	158	158	1,973	45
46	HVAC	1991	6,872		8			6,872	46
47	Roof	1992	30,828		20	1,541	1,541	17,723	47
48	Sealcoating	1993	2,650		8			2,650	48
49	Hot Water Heater	1993	3,075		15	205	205	2,153	49
50	HVAC	1993	6,230		8			6,230	50
51	Security System	1993	1,365		10	137	137	437	51
52	HVAC	1995	3,250		8	406	406	3,248	52
53	Water Heater	1995	2,500		10	250	250	2,000	53
54	Ventilators	1995	3,145		8	392	392	3,136	54
55	Bathroom Tile	1995	4,278		20	214	214	1,712	55
56	Bathtub	1995	12,353		15	824	824	6,592	56
57	HVAC	1995	6,906		8	864	864	6,906	57
58	Paving Bus Area	1995	3,990		15	266	266	2,128	58
59	Front End	1984	13,115		30	438	438	8,102	59
60	Carpeting	1995	16,348		8	2,044	2,044	14,308	60
61	Roof Cooler	1995	1,300	163	8	163		1,141	61
62	Hot Water Heater	1996	2,500		8	313	313	2,191	62
63	Remodeling	1996	7,221	362	20	362		2,172	63
64	Canopy	1996	12,300	1,230	10	1,230		7,380	64
65	HVAC	1997	2,246	280	8	280		1,680	65
66	Soffit & Facia	1997	12,782	1,278	10	1,278		7,668	66
67	Sealcoating	1997	11,000	1,376	8	1,376		8,256	67
68	Fence	1997	5,091	254	20	254		1,524	68
69	Water Heater	1998	8,300	1,038	8	1,038		5,190	69
70	TOTAL (lines 4 thru 69)		$ 1,705,080	$ 42,787		$ 56,836	$ 14,049	$ 1,030,213	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,705,080	$ 42,787		$ 56,836	$ 14,049	$ 1,030,213	1
2	Nurses Station	1998	3,880	194	20	194		970	2
3	HVAC	1998	5,635	704	8	704		3,520	3
4	Sealcoating	1998	11,000	1,375	8	1,375		6,875	4
5	Electrical	1998	6,368	318	20	318		1,590	5
6	A/C	1999	6,800	680	10	680		2,720	6
7	Security System	1999	1,200	120	10	120		480	7
8	Patio Cover	1999	11,205	560	20	560		2,240	8
9	HVAC	2000	2,450	306	8	306		918	9
10	Roof	2000	1,250	83	15	83		322	10
11	Parking Lot	2001	29,300	2,930	10	2,930		4,395	11
12	Screen in canopy	2002	16,486	824	30	824		824	12
13	Slope renovation	2002	14,500	242	30	484	242	242	13
14	Sidewalk	2002	1,900	63	30	126	63	63	14
15	Women Shower	2002	60,000	1,000	30	2,000	1,000	1,000	15
16	Bathroom renovation	2002	198,403	3,306	30	6,612	3,306	3,306	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,075,457	$ 55,492		$ 74,152	$ 18,660	$ 1,059,678	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 198,283	$ 14,560	$ 14,560	$		$ 133,785	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	229,693					229,693	73
74								74
75	TOTALS	$ 427,976	$ 14,560	$ 14,560	$		$ 363,478	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1997 Dodge Van	1998	$ 22,800	$ 2,639	$ 5,700	$ 3,061	4	$ 21,114	76
77										77
78										78
79										79
80	TOTALS			$ 22,800	$ 2,639	$ 5,700	$ 3,061		$ 21,114	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,701,233	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 72,691	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 94,412	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 21,721	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,444,270	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 481 Description: various one time rentals
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)		6,012		6,012
4	Clinical Wages	(b)		6,012		6,012
5	In-House Trainer Wages	(c)		8,800		8,800
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 20,824	$	$ 20,824
10	SUM OF line 9, col. 1 and 2	(e)	$ 20,824			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	18
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	18

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Aspire on Eastern # 0020438 **Report Period Beginning:** 7/01/01 **Ending:** 6/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 136,602	1
2	Cash-Patient Deposits		52,351	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		2,355,815	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		154,633	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		86,773	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 2,786,174	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,791,282	13
14	Buildings, at Historical Cost		9,676,156	14
15	Leasehold Improvements, at Historical Cost		373,337	15
16	Equipment, at Historical Cost		2,378,155	16
17	Accumulated Depreciation (book methods)		(4,884,622)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **deposit**		7,537	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 9,341,845	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 12,128,019	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 732,439	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		52,351	28
29	Short-Term Notes Payable		1,699,576	29
30	Accrued Salaries Payable		916,786	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 3,401,152	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,477,906	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,477,906	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 8,879,058	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,185,736	$ 3,248,961	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,185,736	$ 12,128,019	48

***(See instructions.)**

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 774,671	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 774,671	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	411,065	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 411,065	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,185,736	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,504,702	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,504,702	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	65,052	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 65,052	23
	D. Non-Operating Revenue		
24	Contributions	463,253	24
25	Interest and Other Investment Income***	1,139	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 464,392	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Capital Grants-DCCA & CDBG	163,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 163,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,197,146	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	942,136	31
32	Health Care	2,350,231	32
33	General Administration	1,069,495	33
	B. Capital Expense		
34	Ownership	176,947	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	247,272	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,786,081	40
41	**Income before Income Taxes (line 30 minus line 40)****	411,065	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 411,065	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,728	2,080	$ 51,319	$ 24.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	12,137	13,950	255,706	18.33	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	2,421	2,783	48,286	17.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,735	2,103	28,878	13.73	14
15	Cook Helpers/Assistants	19,636	21,344	176,519	8.27	15
16	Dishwashers					16
17	Maintenance Workers	7,592	8,726	122,245	14.01	17
18	Housekeepers	20,139	23,148	197,227	8.52	18
19	Laundry	4,105	4,718	39,393	8.35	19
20	Administrator	1,834	2,080	46,262	22.24	20
21	Assistant Administrator	3,055	3,512	72,978	20.78	21
22	Other Administrative	8,600	9,885	257,888	26.09	22
23	Office Manager					23
24	Clerical	6,477	7,445	74,967	10.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	8,084	9,292	127,853	13.76	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	145,500	167,241	1,623,910	9.71	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Program transp	574	660	7,250	10.98	33
34	TOTAL (lines 1 - 33)	243,617	278,967	$ 3,130,681 *	$ 11.22	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	204	$ 9,375	1	35
36	Medical Director	58	8,700	9	36
37	Medical Records Consultant	11	280	12	37
38	Nurse Consultant	192	5,760	12	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	65	3,262	12	40
41	Occupational Therapy Consultant	320	19,234	12	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	178	10,665	12	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psycharist	105	9,930	9	46
47	Neurologist	12	1,787	9	47
48					48
49	TOTAL (lines 35 - 48)	1,145	$ 68,993		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Vicki Pollick	administrator	0	$ 46,262
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 46,262

B. Administrative - Other

Description	Amount
See Schedule VIII	$ 150,354
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 150,354

C. Professional Services

Vendor/Payee	Type	Amount
BDO Seidman	audit	$ 5,897
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 5,897

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,127
Unemployment Compensation Insurance	19,470
FICA Taxes	239,497
Employee Health Insurance	180,882
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
403 b plan	14,174
TOTAL (agree to Schedule V, line 22, col.8)	$ 501,150

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,726
Health Care Worker Background Check	1,395
(Indicate # of checks performed 107)	
Membership/dues/license	148
Subscription/Reference Materials	574
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,843

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,593
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,593

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/01/01 Ending: 6/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Aspire on Eastern # 0020438 **Report Period Beginning:** 7/01/01 **Ending:** 6/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? yes

(2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 27,973 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 247,272
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? 0 Indicate the amount. $ 0

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. $

c. What percent of all travel expense relates to transportation of nurses and patients? 100

d. Have vehicle usage logs been maintained? yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes

g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: BDO Seidman The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.